NEW JERSEY STATE DEPARTMENT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
MANAGED CARE BUREAU
PO BOX 325
TRENTON, NEW JERSEY 08625

SELECTIVE CONTRACTING ARRANGEMENT APPLICATION (SCA)

The information requested in this application is based upon P.L. 1993, C.162, Section 22 and the Selective Contracting Arrangements of Insurers regulation (N.J.A.C. 11:4-37) published in the New Jersey Register on January 18, 1994 with Adopted Amendments published on Monday, June 15, 1998. Copies of this regulation and the application can be obtained from the Department of Banking and Insurance at (609) 292-5436.

Instructions On Completing New Applications:

Complete the application **Cover Sheet** (1 page) and provide all narratives and documents as described in the ensuing sections of the **Submission Requirements (**4 pages plus 3 Tables). Number each narrative and document according to the item number to which it responds (e.g., III. Health Care Services, #5 Quality Assurance Program). Number each page in the upper right hand corner. Tabs should be inserted indicating each of the six major sections of the application as well as the numbered subsections. Number all pages consecutively. Place in a three ring binder with identification on the front and spine. Incomplete applications will be returned.

Small Employers:

If the insurer is offering Selective Contracting Arrangements to small employers (49 or fewer employees) or individuals, the applicant must provide a certification that the policy forms and certificates are properly filed or certified pursuant to N.J.S.A. 17B:27A-1, et seq.

Filing Fees:

A check or money order for $1,500 payable to “New Jersey Department of Health and Senior Services ” shall accompany the two copies of the application sent to that Department at the address below .

New Jersey Department of Banking and Insurance
Life and Health Division
Managed Care Bureau
P.O. Box 325
20 West State Street
Trenton, New Jersey 08625-0325

New Jersey Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza, 6th Floor
P.O. Box 360
Trenton, New Jersey 08625-0360

SELECTIVE CONTRACTING ARRANGEMENT (SCA)

NEW APPLICATION FOR APPROVAL

COVER SHEET

1. Name of Insurer

2. Affiliated Company(s)

3. Address

4. City | 5. County | 6. State | 7. Zip Code

8. Telephone Number | 9. Chief Executive Officer

10. Name of Preferred Provider Organization (PPO) (if one used)

11. Address of PPO

12. City | 13.County | 14. State | 15.Zip Code

16. Telephone Number | 17. PPO President or CEO

I certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

Name and Title (Office of Insurer) | Signature | date

NEW SCA APPLICATION
SUBMISSION REQUIREMENTS

SECTION I.
General:

#1. A narrative description of the health benefit plan(s) to be offered. Specify large group (50 plus employees), small group (2-49 employees) and/ or individuals.

#2. State whether or not the insurer will be entering into direct contracts with providers.

#3. Description and History of any PPO being used in this arrangement. List each PPO and include a description of the insurer's or PPO's experience with managed health care and cost containment. Include certification by the PPO senior officer that the PPO does not assume risk or engage in the business of insurance.

#4. Describe the manner in which benefits may be obtained from both preferred and non-preferred providers.

SECTION II.
Organization/Legal:

#1. Articles of incorporation for the PPO-Department of State authorization to do business in New Jersey.

#2. By-Laws for PPO.

#3. List of owners and investors of the PPO.

#4. Address of the insurer's and PPO's place of business for managed care in New Jersey.

#5. List of Board Members (including names, addresses and occupations) of PPO.

#6. Biographical Affidavits (**pages 8-12 of application**) of officers and directors of PPO's and insurer's managed care division.

#7. Organizational Charts for both the PPO and the Insurer's Managed Care Division

#8. Hold Harmless provision for covered persons.

#9. Description of the grievance procedures including a flow chart.

#10. Copies of executed contracts between the PPO(s) and the insurer

SECTION III.
Health Care Services:

#1. Summary description of the health care delivery systems and how accessibility, quality and utilization controls will be assured. Also include a description of the incentives to use participating providers. [**Attached are general guidelines used by the Department of Health and Senior Services, titled "Health Care Delivery System Standards." These may be used as a guide in describing your own delivery system**.]

#2. Copies of executed provider contracts, such as the Hospital/Facility Agreement, Physician Agreement, Pharmacy Agreement, Mental Health Agreement, etc. There must be executed physician contracts (evidenced by the submission of the contract signature page) sufficient in number and geographical distribution so as to assure accessibility for the number of enrollees projected for the end of the first year of operations. The insurer or PPO shall maintain an adequate number of physicians to provide quality medical treatment for the covered services. In lieu of executed contracts for specialists, secondary or tertiary hospitals and the other covered services, there must be a detailed description of how all services will be arranged for and coordinated. Include a description of the criteria and method used to select preferred providers.

#3. Description of Service Area: Identify the counties in which you are seeking to be approved. **Complete the attached provider tables (Tables 2, 3 and 4).** Submit maps detailing the location of physicians, specialists and inpatient care facilities.

#4. Submit a copy of every standard form of policy or contract.

#5. Quality Assurance Program: Submit a detailed description of how the insurer or PPO will monitor and control quality of care for all its members including complaint resolution, physician peer review, a standardized medical record keeping system, UR programs and case management programs.

#6. Utilization Controls: Submit a detailed description of how the insurer or PPO will monitor utilization as well as develop controls specifically for under-treatment and/or over-utilization, as required by N.J.A.C. 11:4-37. (c) 10.

#7. Emergency Care: Submit a detailed description of how emergency medical services will be available 24 hours a day, seven days a week, and the mechanism and level of reimbursement for emergency care. (N.J.A.C. 11:4-37.3(b)(2.)) Cite where in the policy forms and where in the employee handbook emergency care is defined.

#8. Malpractice Insurance: Submit a signed certification that all the providers in the provider directory have obtained the required $1,000,000/$3,000,000 malpractice insurance minimums.(N.J.A.C 11:4-37.4 (c)(21, ii 7)

#9. Evidence of Coverage: Copy of every standard form of evidence of coverage. Provide detailed information pursuant to N.J.A.C. 11:4-37.3(b) 3. and 4.

#10. Confidentiality of Health Records: Describe how you will protect the privacy of covered members' health records. Demonstrate conformance with N.J.A.C. 11:4-37.3(a)4.

SECTION IV.
Marketing:

#1. Description of marketing projections of membership by rating status and a three year financial pro forma projection reflecting the effect of such enrollment on the financial condition of the insurer in New Jersey.

#2. Submit a marketing plan which explains how the company plans to market in order to meet the projections, such as direct marketing, agents, independent brokers.

#3. Submit the following items: marketing literature, member handbook, provider directory organized by county.

SECTION V.
Financial:

#1. Satisfactory evidence of the PPO's ability to maintain the financial resources necessary to ensure delivery of service:

a. The most recent financial report, or, if a new PPO, its capitalization and projections

b. Last three quarters audited and unaudited financials up to the most recent period: income and expense statements, balance sheet, cash flow statement, changes in financial position.

c. Three year projection of PPO's balance sheet, revenue and expense report and cash flow report with and without this SCA business.

#2. Reimbursement: Procedures to be used among all parties. Trace the actual flow of monies from the time the provider presents his bill until he is reimbursed.

#3. Benefit Differential: A description of the benefit differential between in-network and out-of-network. An actuarial certification that the differential by benefit (coinsurance, deductibles and copayment) doesn't exceed 30% accompanied by the appropriate calculations and actuarial proof including:

a. A comparative exhibit, listing the plans and factors and whether or not they meet the 30% benefit differential test. This should be organized in summary format on one or two pages.

b. A detailed explanation of what each factor represents and how it is calculated.

c. A discussion about the actuarial approach taken and the justification for that approach or why you feel it is appropriate.

[Note: A sample "Actuarial Justification of Benefit Differentials" is attached.]

SECTION VI.
Other

Any other materials specifically requested by the Department of Banking and Insurance and the Department of Health and Senior Services.

SECTION VII.
Small Employer

Certification that individual and/or small employer policy forms and certificates were properly filed or certified pursuant to N.J.S.A. 17B:27A-1, et seq. Send a copy of Exhibit BB, Part l, Certification of Compliance, for the Small Employer Board (SEH), and/or Exhibit Q for the Individual Health Coverage (IHC).

DEPARTMENT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
MANAGED CARE BUREAU

BIOGRAPHICAL AFFIDAVIT

Full name and Address of Entity (Do not use group name).
_____
_____
_____

In connection with the above-named Arrangement, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE", SO STATE. DO NOT LEAVE ANY QUESTIONS UNANSWERED.

1. Affiant's Full Name. _____
_____

2. a. Have you ever had your name changed? _____ If yes, state the reason for the change. _____

b. Other names used at any time. _____
_____

3. Date and Place of Birth. _____
_____

4. Affiant's Business Address. _____
_____

Business Telephone Number. _____

5. List your residence for the last ten (10) years starting with your current address, stating:

Date Address City/State

_____
_____
_____
_____

6. Education: Dates, Names, Locations and Degrees

College _____
_____

Graduate Studies _____
_____

Others _____
_____

7. List memberships in Professional Societies/Association.

_____
_____
_____

8. Present or Proposed Position with the Applicant Entity.

_____
_____

9. List complete employment record (up to and including present jobs, positions, directorates, or officership) for the past twenty- (20) years, stating:

DATES EMPLOYER AND ADDRESS TITLE

_____
_____
_____
_____
_____

10. Present employer may be contacted. Yes _____ No _____
Former employers may be contacted. Yes _____ No _____

11. a. Have you ever been in a position that required a fidelity bond? _____
If any claims were made on the bond, state details. _____
_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? _____
_____

12. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date license issued, issuer of license, date terminated, reasons for termination). _____
_____

13. During the last ten- (10) years, have you ever been refused a professional, occupational, or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____
_____

If yes, state details. _____
_____
_____

14. List any insurers, prepaid dental plans, health care corporations or health maintenance organizations in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power).
_____
_____

If any of the stock is pledged or hypothecated in any way, state details. _____
_____
_____

15. Will you or members of your immediate family subscribe to own, beneficially or of record, shares of stock of the application entity or its affiliates? _____
_____

If any of the shares or stock are pledged or hypothecated in any way, state details.
_____
_____

16. Have you ever been adjudged bankrupt? _____

If so, give details. _____
_____

17. Have you ever been convicted, had a sentence imposed or suspended, had a pronouncement of a sentence suspended, been pardoned for conviction of or pleaded guilty or no contest to any criminal information, indictment or complaint, other than minor traffic violations? _____

If yes, state details. _____
_____
_____

18. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any entity which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation, conservatorship, or bankruptcy? _____

If yes, state details. _____
_____
_____

19. Has the certificate of authority or license to do business of any insurer, prepaid dental plan, health care corporation, or health maintenance organization of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position? _____

If yes, state details. _____
_____
_____

Dated and signed this _____day of _____, _____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

State of _____ County of _____

Personally appeared before me the above named _____ personally known to me, who being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____day of _____, _____.

(SEAL) **_____**
(Notary Public)

My Commission Expires_____